Commonwealth of Virginia

State Health Benefits Program Enrollment Form For Retirees, Survivors And VSDP/LTD Participants

Enroll within 31 days of your retirement or Virginia Sickness and Disability Program (VSDP) long-term disability start date (end of active coverage), or you may forfeit your only opportunity to participate in the health benefits program. An eligible survivor of a retiree/ employee or LTD participant who wishes to continue health benefits coverage must complete this form within 60 days of the enrollee's death. **Keep a copy of your completed form for documentation of your enrollment or change.**

This form must be signed by the Enrollee (Retiree, Survivor, VSDP/LTD participant), not by a dependent.

IF YOU ARE USING THIS FORM TO. . .	COMPLETE PART(S) . . .
• Enroll in plan that coordinates with Medicare	A, B, C, E
• Enroll in Non-Medicare State plan	A, B, D, E
• Enroll in *combination* of plans above	A, B, C, D, E
• Change plans and/or type of membership	A, B, C and/or D, E
• Make an Open Enrollment change (non-Medicare participant only)	A, B, D, E
• Waive or cancel participation in the State Health Benefits Program	F
• Waive coverage in VSDP/LTD due to Open Enrollment or a qualifying mid-year event	A, E
• Enroll in Extended Coverage	Obtain a separate Extended Coverage Enrollment Form

IF YOU ARE A. . . *(check one)*	SEND COMPLETED FORM TO . . .
☐ New Retiree or New Survivor of Active State Employee ☐ New VSDP/LTD Participant	Your Agency Benefits Administrator
☐ Current VRS Retiree or Survivor* ☐ Current VSDP/LTD Participant* * *Including dependents who have separate plans from the Enrollee*	Virginia Retirement System P.O. Box 2500 Richmond, VA 23218-2500
☐ All Other Retirees or Survivors (Optional Retirement Plan, Local Retiree, etc.)	Your former Agency's Benefits Administrator

Part A. Enrollee Information – (Retiree, Survivor or VSDP/LTD Participant Information Only – Not Dependent Information)

Print Name _____ Social Security Number _____
(First) (M.I.) (Last)

Address _____ City _____ State _____ Zip _____

Day Time Phone (_____) _____

Birth Date _____/_____/_____ Sex: ☐ Male ☐ Female E-mail Address _____
Month Day Year

REASON FORM IS BEING SUBMITTED *(Check appropriate category)*

☐ **Initial Enrollment.** *Check one:* ○ Retirement ○ Re-enrolling from dependent status in active/other retiree coverage
○ VSDP/LTD Initial Enrollment/Waiver ○ Survivor Enrollment

☐ **Now Eligible For Medicare.** ○ Retiree/Survivor ○ Spouse ○ Child ○ VSDP/LTD Participant

☐ **Open Enrollment (Non-Medicare Participants Only) To Change Plans And/Or Membership.**
○ Enrollee/Enrollee and Dependents ○ Dependent with Separate Coverage

☐ **VSDP/LTD Participant Enrolling In Single Coverage From Waived Status.**

☐ **Remove Dependent(s) From My Coverage.** (Change will be effective the first day of the month after this form is received.)

Name of Dependent(s) _____ Social Security Number(s) _____

If you are removing a dependent due to a qualifying mid-year event, please indicate the event on page 2.

☐ **Medicare Eligible Member Making Allowable Plan Change.** (Effective date will be the first of the month after this form is received.)
○ Retiree/Survivor ○ Spouse ○ Child ○ VSDP/LTD Participant

☐ **Qualifying Mid-Year Event (Life Event)**. Check the type of event on page 2, and attach the appropriate supporting information as indicated. Please complete enrollee information in Part B. Submit this change within 31 days of the event. In most cases, the change will be effective the first day of the month following receipt of request.

(Part A. continues on page 2)

Qualifying Mid-Year Events (Event/*Attach This Information*) **Date of Event** _____

Change In Enrollee's Marital Status
- ☐ Marriage/*Marriage Certificate*
- ☐ Divorce/*Final Divorce Decree*
- ☐ Death of spouse/*Death Certificate*

Change In Enrollee's Number of Dependents
- ☐ Birth/*Birth Certificate*
- ☐ Adoption, placement for adoption/*Adoption Agreement*
- ☐ Covered child loses eligibility (exceed plan's age limit, marries, becomes self-supporting, etc.)
- ☐ Court order to cover child/*Court Order*
- ☐ Permanent custody of a child
- ☐ Gains eligibility for Medicare or Medicaid (and cancels state coverage)/*Government Documentation*
- ☐ Loses eligibility for Medicare, Medicaid, or another government-sponsored plan (and adds State coverage)/*Government Documentation*

Change In Enrollee's Number of Dependents *(continued)*
- ☐ Spouse or child begins employment/*Employer Letter*
- ☐ Spouse or child ends employment/*Employer Letter*
- ☐ Spouse or child begins leave without pay/*Employer Letter*
- ☐ Spouse or child ends leave without pay/*Employer Letter*
- ☐ Death of covered child/*Death Certificate*
- ☐ Department of Social Services (DSS) order to cover a child/*DSS order*
- ☐ Spouse or eligible/covered child switched from full-time to part-time employment or vice versa

Other Changes
- ☐ Annual/Open Enrollment or change allowed under another employer's plan/*Employer Letter*
- ☐ Permanently moves in or out of plan's service area
- ☐ Special Enrollment under HIPAA
- ☐ Permanent change in residence affecting eligibility for coverage
- ☐ A court has required that another party cover your children

TYPE OF MEMBERSHIP

Please select the membership type which best describes the coverage for which you are enrolling:

☐ **Single Coverage** ☐ **Two people** ☐ **Family** – Enrollee with Two or More Dependents (any or none may have Medicare)

☐ **Waive VSDP/LTD health coverage due to your State Open Enrollment, or due to a qualifying mid-year event (indicate event above)**

Part B. Enrollment

List all Medicare and Non-Medicare Enrollees. Include yourself and everyone you are enrolling in a health plan (include all participants, not just additions). Attach a copy of Medicare cards for all members who are Medicare-eligible.

Relationship Codes: E = Retiree, LTD or Survivor H = Husband W = Wife S = Son D = Daughter SS = Stepson SD = Stepdaughter O = Other child

NAME	Birthday MM/DD/YYYY	Social Security Number	Relationship Code	Medicare Information (if applicable)		
				Medicare Claim #	Part A Effective Date	Part B Effective Date

HEALTH BENEFITS PLAN SELECTION

Members must select a plan based on their Medicare eligibility. Members who are eligible for Medicare, regardless of age, must select a plan in Part C, and those who are not eligible for Medicare must select a plan in Part D. The only exception is for members in Family coverage. In that case, Family coverage may be maintained under COVA Care (in Part D), but Medicare will be primary payor for the Medicare-eligible member(s). Enrollment in a Medicare-coordinating plan must take place immediately upon any participant's eligibility for Medicare.

Part C. Plans For Medicare Retirees

If you are Medicare eligible and have not secured both Hospital Part A and Medical Part B of Medicare, contact your local Social Security Administration office.

Please select a plan below and indicate whether the coverage is for you, your spouse, or a dependent child.*

PLAN	COVERAGE FOR (check all that apply)
☐ **Advantage 65**	☐ Retiree/Survivor ☐ VSDP/LTD ☐ Spouse ☐ Child
☐ **Advantage 65 with Dental/Vision**	☐ Retiree/Survivor ☐ VSDP/LTD ☐ Spouse ☐ Child

The plans below may be selected only by members currently enrolled in Option I/Medicare Complementary, or Option II/Medicare Supplemental.*

PLAN	COVERAGE FOR (check all that apply)
☐ **Option I**	☐ Retiree/Survivor ☐ Spouse ☐ Child
☐ **Option II**	☐ Retiree/Survivor ☐ Spouse ☐ Child
☐ **Option II with Dental/Vision**	☐ Retiree/Survivor ☐ Spouse ☐ Child

***Dental/Vision coverage may be added to either Advantage 65 or Option II at any time, and it may be canceled at any time. However, once the Dental/Vision option has been elected and canceled one time, it may not be elected again. Participants in Option I or Option II may enroll in Advantage 65 at any time. However, once enrolled in Advantage 65 (or Advantage 65 with Dental/Vision), neither Option I nor Option II may be elected again. If you add Dental/Vision to Advantage 65 or Option II, your election is effective the first of the month following receipt of your request.

Part D. Plans For Non-Medicare Retirees

All non-Medicare family members must enroll in the same plan. To ensure in-network coverage, use physicians and facilities that participate in your plan's provider network. Contact the plan or visit its Web site for a list of providers. For services outside Virginia, members of the COVA Care plan should use the Anthem BlueCard PPO network. Consult your Member Handbook for additional information.

SELF-FUNDED STATEWIDE PLANS*
Administered by Anthem Blue Cross and Blue Shield

☐ COVA Care Plan (includes basic dental) (CC0)
☐ COVA Care + Out-of-Network (CC1)
☐ COVA Care + Expanded Dental (CC2)
☐ COVA Care + Out-of-Network + Expanded Dental (CC3)
☐ COVA Care + Vision + Hearing + Expanded Dental (CC4)
☐ COVA Care + Out-of-Network + Vision + Hearing + Expanded Dental (CC5)

** Coverage available to participants outside Virginia*

REGIONAL FULLY FUNDED HMO (NORTHERN VIRGINIA)

☐ Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. – HMO**(KP)

***Note: Kaiser plan members must select a primary care physician*

Part E. Authorization, Enrollee Statement, And Certification

ENROLLEE STATEMENT: I want to enroll in the Retiree Health Benefits Program. The cost of coverage will be deducted from my Virginia Retirement System (VRS) retirement check. If I am not receiving a VRS monthly benefit, or if my VRS monthly retirement payment is not large enough to deduct my health insurance premium, I will be billed directly. To cancel coverage, I must send my request in writing to the address noted on page 1. Cancellation of coverage will be effective the end of the month in which my written request is received. I understand that notice of cancellation does not relieve me from payment for monthly coverage that has already begun. If I cancel my state retiree coverage, I will not have another opportunity to enroll in the Retiree Health Benefits Program. I understand that my health premiums are subject to change. I am aware that the Commonwealth reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability. I understand that non-payment of premiums will result in cancellation of coverage and will permanently revoke my eligibility for the program.

CERTIFICATION/AUTHORIZATION: I certify that I have reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the state's health benefits program and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Enrollee's Signature[1] _____ **Date** _____

Print Name _____

[1] *Dependents are not authorized to sign this form*

Part F. To Waive Or Cancel State Coverage

RETIREES AND/OR SURVIVORS

Name _____ Effective Date _____
(First) (M.I.) (Last) (MM/DD/YYYY)

Social Security Number _____ Telephone Number _____

WAIVE COVERAGE

☐ **I am a retiree and do not wish to enroll in the State Health Benefits Program for retirees at this time. However, I will continue my membership under the Active or Retiree State Health Benefits Program through my spouse.** I understand that upon my spouse's retirement, termination of state employment, death, or other consistent qualifying mid-year event, I will be eligible to apply for retiree coverage only within 31 days of that event.

☐ **I am a retiree who has become eligible for coverage in an active state plan and I wish to waive coverage.** I understand that I may re-enroll in the retiree program within 31 days of the loss of active coverage and that I must have maintained continuous coverage in the State program.

(Part F. continues on page 4)

(PART F. CONTINUED)

CANCEL/DECLINE COVERAGE

☐ **I am a new retiree* and do not wish to enroll in the State Health Benefits Program for retirees.** This applies to me and my eligible family members. I understand that I will not have another opportunity to enroll except as allowed above. See above Waive section.
*Includes retirees ending a 12-month severance benefit period.

☐ **I am a current retiree/survivor and wish to cancel my coverage in the State Health Benefits Program for retirees.** I understand that neither I nor my dependents will be permitted to re-enroll in the program at any time. This serves as my written notification and authorization to cancel my coverage and that of my dependents.

If you are entitled to a Health Insurance Credit, waiving or canceling State coverage does not affect your credit eligibility. You may participate in the Alternate Health Insurance Credit Program, which is administered by VRS.

Signature _____ **Date** _____

VSDP/LTD PARTICIPANTS

Name _____ Effective Date _____
(First) (M.I.) (Last)

Social Security Number _____ Telephone Number _____

WAIVE COVERAGE AT START OF LTD (For waiver of existing LTD coverage due to State Open Enrollment or a qualifying mid-year event, see part A.) An Enrollment form must be submitted within 31 days of starting LTD. At any time after enrollment, nonpayment of premiums will result in termination of coverage for the duration of long-term disability.

☐ **I am a new VSDP/LTD participant and do not wish to enroll in the State Health Benefits Program for retirees.** This applies to me and my eligible family members. I understand that I will not have another opportunity to enroll unless I experience a qualifying mid-year event or Open Enrollment. (Open Enrollment is available to non-Medicare participants only).

☐ **I am a VSDP/LTD participant and do not wish to enroll in the State Health Benefits Program for retirees at this time. However, I will continue my membership under the Active or Retiree State Health Benefits Program through my spouse.** I understand that upon my spouse's retirement, termination of state employment, death, or other consistent qualifying mid-year event, I will be eligible to apply for retiree group coverage only within 31 days of that event.

If you are entitled to a Health Insurance Credit, waiving or canceling coverage does not affect your credit eligibility. You may participate in the Alternate Health Insurance Credit Program, which is administered by VRS.

Signature _____ **Date** _____

Agency Approval/Agency Use Only (For New Retiree Group Members)

I understand that the agency Benefits Administrator is responsible for the initial setup of the retiree's, active survivor's or VSDP/LTD participant's record on the Benefits Eligibility System (BES). The agency Benefits Administrator is also responsible for forwarding a copy of the completed enrollment form to VRS.

Agency Name _____ Date Form Received _____ Coverage Effective Date _____

I have reviewed this form, and verified that the retiree, survivor or VSDP/LTD participant is eligible for the plan or waiver selected. I certify that the information on this form is complete and accurate to the best of my knowledge.

Agency Representative's Signature _____ Date _____

Print Name and Title _____ Phone Number _____

This participant is enrolling as:

☐ Virginia Retirement System Retiree/Survivor ☐ Local Retiree/Survivor ☐ ORP Retiree/Survivor (name of plan) _____
☐ VSDP/LTD Participant ☐ Non-Annuitant Survivor

The participant has been told that the first premium would be in the amount of $ _____

If retiring, indicate type of retirement: ☐ Service Retirement ☐ Disability Retirement Retirement Date: _____

VRS Use Only (For Existing Retiree Group Members)

Date Form Received _____ Effective Date of Change (subject to DHRM approval) _____

For Disability Retirees:

Date of Approval Letter _____ Date of Retirement _____